

NOTICE OF INDEPENDENT REVIEW DECISION **CORRECTED LETTER**

NOTE: Rationale/Basis for Decision

July 16, 2002

RE: MDR Tracking #: M2-02-0708-01
IRO Certificate #: IRO 4326

The ____ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ____ physician reviewer who is board certified in anesthesiology which is the same specialty as the treating physician. The ____ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ____ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 40-year-old female sustained an on-the-job back injury on ____ when she fainted and fell. The clinical and diagnostic work-up revealed lumbar strain/sprain, lumbar radiculopathy and myofascial pain syndrome. The plan of care included a chronic pain management program with a treatment recommendation for right lumbar facet injections at 4 levels and six physical therapy visits, post injection.

Requested Service(s)

Right lumbar facet injections at 4 levels and six physical therapy visits, post injection

Decision

It has been determined that the right lumbar facet injections are medically necessary.

It has been determined that six physical therapy visits, post injection, are not medically necessary.

Rationale/Basis for Decision

Facet injections are indicated. The patient's pain, of more than four weeks duration, is axial and referred to the leg. The pain has been unresponsive to previous treatment. The patient had one previous facet block with good response according to _____. The North

American Spine Society (NASS) guidelines allow facet blocks in the tertiary phase of care (longer than six months) in attempts to facilitate active treatment. Up to three injections per year are appropriate when used to facilitate other avenues of care. Therefore, the documentation submitted for review substantiates that the right lumbar facet injections are medically necessary.

Physical therapy is not recommended in the tertiary phase of treatment (after six months) according to the NASS. The patient has already undergone a comprehensive rehabilitation program and should know the exercises to perform after the injection. Therefore, the documentation submitted for review does not substantiate that six physical therapy visits, post injection, are medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,

cc: Rosalinda Lopez, Program Administrator, Medical Review Division, TWCC

In accordance with Commission Rule 102.4 (h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 25 th day of July 2002.
